AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name First Name	Date of Birth (Mo/Dy/Yr)
HEREBY AUTHORIZES	
□ LAC+USC Medical Center	☐ Rancho Los Amigos National Rehabilitation Ctr.
□ Olive View-UCLA Medical Center	☐ High Desert Multi-Service Ambulatory Care Ctr.
□ Harbor-UCLA Medical Center	□ Martin Luther King, Jr. Multi-Service
	Ambulatory Care Center
□ CHC/Health Center:	
☐ Antelope Valley Community Clinic	□ Central Neighborhood Health Center
□ Community Health Alliance of Pasadena	□ JWCH, Inc.
☐ Korean Health Education & Research Ctr.	☐ Los Angeles Christian Health Center
☐ Mission City Community Network	□ St. John's Well Child & Family Clinic
□ Other: Facility Name Street Address	Out Obels 7's Code
To Release Protected Health Information To	City State Zip Code
To Release Protected Health Information To	•
Department of Public Social Services District Office Name	Street Address
City	State Zip Code
Fauthor time popied heatinging	and anding
For the time period beginning,,	Date
EXPIRATION DATE: This authorization is valid	l until the following date://20
INFORMATION TO BE DISCLOSED	
PLEASE CHECK ALL APPROPRIATE BOXES:	
□ Discharge Summary □ M	ental Illness or Mental Health Assessment
- Discharge Summary	rug and/or Alcohol Abuse Treatment
	mptomatic HIV/AIDS
	exually Transmitted Disease (s)
	KG Report
	EG Report
	ummary of Medical History / Treatment
□ Medical Progress Notes	······································
□ Other (Please Specify)	
	

COUNTY OF LOS ANGELES THE PURPOSE OF THE DISCLOSURE – PROVIDE A DESCRIPTION OF THE PURPOSE OF INTENDED USE AND DISCLOSURE		
I understand and agree to have my health care		
provider complete and return ABP 1676-1 form to Department of Public Social Services (DPSS)		
so they can determine my eligibility to receive benefits.		
I understand that health information used or disclosed as a result of my signing this Authorization		
may not be further used or disclosed by the recipient unless another authorization is obtained		
from me or unless such use or disclosure is specifically required or permitted by law.		
YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:		
Right to Receive a Copy of This Authorization – I understand that if I sign this authorization, I		
will be provided with a signed copy of the form.		
CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my		
ability to obtain treatment from my health care provider but doing so may impact my eligibility to		
receive DPSS benefits.		
I have had an opportunity to review and understand the content of this authorization form. By		
signing this authorization, I am confirming that it accurately reflects my wishes.		
Signature of Patient/Legal Representative Print Name Date		
If signed by other than the patient, state relationship and authority to do so: Date:/		
Witness: Print Name		
Right to Revoke This Authorization – I understand that I have the right to revoke this Authorization at any time by telling DPSS in writing. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:		
I also understand that a revocation will not affect the ability of DPSS or any health care provider to use or disclose the health information or reasons related to the prior reliance on this Authorization.		
REVOCATION OF AUTHORIZATION		
Signature of Patient/Legal Representative: Date:		
If signed by other than patient, state relationship and authority to do so:		